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ABSTRACT

Several states are helping families leave or avoid welfare by developing innovative responses to critical "employment enablers": transportation, health care coverage, and child care. This report: (1) examines why lack of transportation, health insurance, and child care are barriers to work; (2) identifies how funding sources can be accessed and used to enhance programs; and (3) examines state policy alternatives to make work a feasible option for poor families. The report is divided into separate sections on funding sources, transportation, health care coverage, and child care assistance, with key findings and state and federal program alternatives presented on separate fact sheets. Highlighted programs to improve access to transportation include the Job Access and Reverse Commute federal program. Health insurance programs include the new child health block grant to states. Child care assistance efforts include new block grants for states and transfer of TANF funds into the child care block grant. Individual sections contain references. (KB)

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State Investments to Make Work Feasible

Child Care, Health Care, and Transportation Policies for Low-Income Families

April 1999



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State Investments to Make Work Feasible

Overview and Sources of Funding

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REPORT SUMMARY

A number of states are helping families leave or avoid welfare by developing innovative responses to transportation, health care coverage, and child care expansion and subsidies to support employment. These actions are backed by a growing consensus among welfare recipients, policy makers, and the American public that these factors are the critical employment enablers.

Policies that make work feasible will play a critical role in the future success of welfare reform. New avenues of federal funding exist to begin to bring about viable solutions to these potential barriers to employment, but much work lays ahead for state and federal policy makers.

- Comprehensive assessments, collaborative planning and identification of matching funds must proceed the implementation of transportation solutions.
- Policy changes and authorization of state funding are necessary to realize the full potential of the Medicaid and child health insurance (CHIP) programs in providing access to health care for low-income uninsured families.
- Development of child care services addressing unmet needs and accessing sufficient funding are the primary challenges for child care assistance.

In addition to establishing and funding the supports, states must ensure that services are reaching those who need them. While new federal dollars, along with state investments, allow for expansion of supports, they do not serve as incentives to leave welfare if recipients are not aware of them. State studies of families leaving welfare, compiled by the National Governors' Association, show that a large number of former recipients are not made aware that they may continue to be eligible for child care, Medicaid, food stamps, or other assistance (NGA, 1998). A Wisconsin study found that only half of those parents declared "job ready" had received information about child care assistance; only 10% knew that help was available for transportation (IWF, 1998). Lack of better outreach may be the result of case managers overwhelmed with the responsibility of informing recipients of the many requirements and facets of complex new programs, but states must address this problem for welfare reform to achieve the goal of successfully transitioning families from welfare to work.

The current patterns of job and wage growth suggest that supports to low-wage earners to provide some degree of economic stability are necessary over an extended period of time. To the extent that these families' earnings remain low and their employment-based fringe benefits remain limited, their continued ability to work may depend to a great extent on the availability of such employment-related supports. For parents transitioning off welfare and other low-wage earners, transportation assistance, Medicaid coverage, and child care assistance may be the difference between maintaining employment and self-sufficiency, or resorting to welfare to provide for their families.

INTRODUCTION

What Is Necessary to Make Work Feasible

Requiring welfare recipients to participate in work activities does not, by itself, make it feasible for them to leave welfare behind. Cash assistance is essential to help them meet expenses when they have insufficient earnings or child support, and training and education will help them get better jobs. However, other work-related investments are needed for welfare recipients to enter and remain in the work force and still be good parents to their children. For many, there is no means of *transportation* to get to jobs, *child care costs* can consume most of their paychecks, and paying for *health care coverage* can take the rest of their earnings. There is growing recognition among experts and policy makers that these three factors are critical employment enablers.

The majority of welfare recipients favor time limits on the receipt of cash assistance benefits, but they are concerned about finding adequate child care and health care coverage for their children when they go to work. Many of the participants in a recent multi-city study emphasized that the non-cash benefits were as important, if not more so, than cash benefits (Burton et al, 1998). In a study conducted by the Southern Regional Institute on Children and Families, recipients were asked what benefit they considered most important to enable them to work. Almost half (48%) reported child care, 32% reported health care coverage for their children, and 12% reported transportation (Brown et al, 1998). When former welfare recipients in Florida were surveyed, nearly half said that their ability to go to work had been strongly influenced the availability of child care and transportation. Only a little over one-fourth said that time limits on benefits had a strong influence on their decision (Bloom et al, 1998).

The American public recognizes the importance of these supports in aiding families transitioning from welfare to work. In a telephone survey of households in all 50 states, respondents identified health insurance for the uninsured, assistance paying for child care and work-related transportation, along with housing assistance and basic education, as key investments necessary for families transitioning off welfare. The public also wants to see these same supports provided to the working poor. Eighty-six percent advocate making child care assistance available to all low-income families, as well as health insurance for uninsured low-income families (Kellogg, 1999). Possibly because of this strong public support, federal funding is now available to states to address each of these issues, at least on a partial basis.

This report (1) examines why lack of transportation, health insurance, and child care represent barriers to work, and what some states are doing to address this; (2) identifies sources of funding, what states must do to access it, and how funding streams can be enhanced; and (3) examines state policy alternatives to make work a feasible option for poor families.

Overview of Funding Sources for Transportation, Health Care Benefits, and Child Care

Beginning with the passage of the 1996 federal welfare law, the federal government recognized that states would need more funds for support services for families to transition successfully from welfare to work. The new earmarked funds -- each of which require state matching funds -- are:

- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) included funds for expanded child care assistance through the Child Care Development Block Grant (CCDBG) that consolidated four major sources of federal child care subsidies for low-income children into the Child Care Development Fund (CCDF). The legislation provided up to \$2.97 billion in federal funding for the CCDF in FY 1997, to increase to \$3.7 billion in the year 2002.
- In July 1997, Congress passed the Balanced Budget Act (BBA) which offered states \$20.3 billion over the next five years to provide health care coverage to uninsured children through newly created state child health insurance programs (CHIP). Provisions in PRWORA also make it possible for states to provide Medicaid coverage to more working poor parents.
- In June 1998, the Transportation Equity Act for the 21st Century (TEA-21) was enacted. This act created the Job Access and Reverse Commute grant program allocating up to \$150 million for the Access to Jobs initiative for the next five years. Funding assists states and localities develop flexible transportation services to connect welfare recipients and other low-income persons to jobs and other employment-related services.

In addition to these earmarked sources of revenue, states may utilize other revenue streams to help make work feasible.

- PRWORA allows a state to use both its federal block grant money for Temporary Assistance to Needy Families (TANF)¹ and the required state maintenance-of-effort (MOE) funds for transportation and child care assistance. By the end of FY'98, approximately \$3 billion in federal TANF funds for FY'97 and FY'98 combined were left unexpended and unobligated² (Falk, 1999).
- BBA provides \$3 billion for Welfare-to-Work grants (WtW) to pay for a variety of employment-related activities aimed largely at individuals on welfare facing significant work barriers. Although initial funding was only for FY'98 and FY'99, the President's FY 2000 budget proposal includes \$1 billion to extend the Welfare-to-Work grants for a third year.

¹ PRWORA replaced Aid to Families with Dependent Children (AFDC) and JOBS (the former work program) with the TANF program. Giving states flexible funding and much latitude in designing their own welfare programs, TANF also created both a strong requirement and opportunity for recipients to engage in work before reaching a time limit on benefits.

² States may have unexpended TANF funds that are obligated through prior contractual agreements.

Specific requirements that are to be met to access each of these funding sources will be discussed in more detail in the respective sections of this report.

See the "References and Resources" section of this report for identification of reference cites.

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Assisting with Transportation to Work

Lack of Transportation Presents Obstacles to Work

- Frequently a mismatch exists between the location of available entry-level jobs and where welfare recipients live. While two thirds of new entry-level jobs are in the suburbs, three out of four welfare recipients live in rural areas or central cities. (1)
- With less than one-third of welfare recipients owning cars, most can not rely on private vehicles to get to work. (2)
- Schedules and routes for public transit systems are designed to bring employees living in the suburbs to their jobs in the city, not the reverse. The transportation barrier is magnified for poor Americans living in rural counties, 40% of which have no public transit services. (1)
- Studies have shown that the majority of recipients leaving the welfare rolls will find themselves working in low-wage jobs with some evening or weekend hours, when public transportation service is greatly reduced or stopped entirely. (3, 4, 5)

Options to Make Transportation Available to More Poor Families

- Through the new Job Access and Reverse Commute federal program, \$75 million will be appropriated in FY'99 to expand transportation options. States can use TANF and Welfare-to-Work (WtW) funds as part of the match required to receive the Access to Jobs grants.
- Access to Jobs projects target families whose incomes are below 150% of the poverty level, who need new or expanded transportation services to get to and from jobs and employment-related services like child care.
- Access to Jobs grants can be used to finance capital and operating costs for projects, such as adding late night and weekend service, initiating shuttle service, offering guaranteed rides home, providing demand responsive van service, or sponsoring ride-sharing activities.
- TANF and WtW funds also can be used by states to purchase individual transit passes or to reimburse expenses related to operating a personal vehicle, such as repairs or insurance. If utilizing public transportation is not an option and car ownership is out of reach, TANF funds can be used for loans to lease or purchase a car.
- States have left approximately \$3 billion in federal TANF funds from FY'97 and FY'98, still unexpended and unobligated at the end of FY'98. (6) These funds offer states the opportunity to respond to otherwise formidable transportation barriers*.

* States may intend to hold some of the unexpended TANF funds in reserve for the eventual "rainy day" of a downward turn in the economy and increased demand for cash assistance.

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Filling the Health Care Benefits Gap

Why the Poor Lack Health Care Coverage

- In 1997, 46% of poor working parents did not have health insurance for themselves. In fact, they are uninsured at twice the rate as their unemployed counterparts. (1)
- Some 43 states do not provide Medicaid coverage to working parents who earn enough to bring their family just to the poverty level; in half of the states, working parents are ineligible for Medicaid if their earnings exceed 59% of poverty. (1)
- Despite low unemployment and increased economic growth, the number of uninsured children increased from 10 million in 1995 to 11 million in 1996, or 15% of all children. Children living in the South and Southwest are much more likely to be uninsured than those living in the rest of the country. (2)
- More than two-thirds of uninsured children come from low-income families, and the majority of these children have at least one parent who works full-time. (2)
- Forty percent of working parents with uninsured children work for employers who do not offer health insurance, and another 15% are not eligible for their employer's insurance. (3)
- Greater coverage is available for children, but many are not enrolled. In 1996, 3.4 million children were eligible for Medicaid but not enrolled. This means that 23% of children who were eligible for Medicaid were uninsured by either public or private coverage. (4)

Ensuring More Low-Income Families and Children Get Medicaid Coverage

- Although in recent years Medicaid provision changes have made more low-income families eligible, participation has decreased. Since August 1996 when the federal welfare law was signed, Medicaid enrollment has declined by 8 to 15% in several of the largest states. (5)
- Contributing factors to the nationwide decline in Medicaid enrollment include agency errors, new sanctions under TANF, lack of awareness of eligibility for Medicaid even when not eligible for TANF benefits, a mistaken belief by recipients that all assistance - including Medicaid - is time limited, and general state discouragement (often illegal) of the poor from seeking any type of public assistance.
- A new child health block grant creates the child health insurance program (CHIP) offering states \$20.3 billion over five years to provide health care coverage to uninsured, low-income children. The federal law allows for uninsured children under age 19 living in families with incomes under 200% of poverty to be included in CHIP.

- Twenty states cover children up to or above the general CHIP ceiling of 200% of poverty; all but two states cover children through age 18. (6)
- Estimates have found CHIP funding to be more than sufficient to cover all eligible children at these upper allowable limits.(7) If states choose to disregard a substantial amount of parental earnings or raise the asset limit, even more uninsured children could be deemed eligible for CHIP coverage.
- States also can adopt more comprehensive methodologies for evaluating *countable* income and assets in determining Medicaid eligibility for the working parents of these children.

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Investing in Child Care Assistance

"Work, Not Welfare" Puts a Strain on Child Care Subsidies

- In 1990, impoverished families purchasing child care spent an average of 33% of their income on care for their children. (1)
- A past GAO survey found that if AFDC recipients received child care subsidies, work participation rates increased from 29% to 44%, even at a time when there were no time limits on benefits or strict work requirements. (2)
- In a recent evaluation of the new Florida welfare program, assistance with child care and other supports was named almost twice as frequently as time limits in influencing the decision to get a job. (3)
- Federal child care funds allow states to provide subsidies to families who are working or preparing for work, and who have incomes up to 85% of a state's median income.
- Yet, state child care subsidy programs are so under-funded, many states set eligibility limits to cover only the poorest families. Even under the stricter limits, about half of the states turn away non-welfare, low-income working families or put them on waiting lists to stretch subsidies. (4)
- In 22 states, low-wage earning families are asked to spend more than 10% of their income in co-payments for child care expenses, and 40 states impose a fee on families whose income falls below the poverty level. (5)

How to Maximize the Available Funding for Child Care

- The new Child Care Development block grant provided states with \$3 billion in federal funds for child care in FY'97. If states maintained their previous level of expenditure for child care and met the match for additional federal funds, funding increases to \$4.4 billion. (6)
- A recent Urban Institute study estimated that only about 48% of the potential child care needs of low-income families will be met even when all the federal funds earmarked for child care are drawn down by the states. (7)
- States are also allowed to transfer up to 30% (or approximately \$4.9 billion in FY'97) of their TANF funds into the child care block grant. Only if states transfer the full amount each year, and maximize all available child care federal matching dollars, will they have enough funds to serve all eligible children potentially in need of child care assistance. (7)

- In fact, states have left unexpended and unobligated about \$3 billion in TANF funds from FY'97 & '98.⁽⁸⁾ Although some funds should be held in reserve for the eventual "rainy day" of an economic downward turn, some can be invested in the future by supporting child care to make it feasible for parents to work now.

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State Investments to Make Work Feasible

Assisting with Transportation to Work

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ASSISTING WITH TRANSPORTATION TO WORK

Lack of Transportation Presents an Obstacle to Work

As noted by the U.S. Department of Health and Human Services (HHS), "Transportation is one of the main challenges facing people making the transition from welfare to work" (1998). Frequently a mismatch exists between the location of available entry-level jobs and where many welfare recipients live. According to HHS, two-thirds of new jobs are in the suburbs, but three of four welfare recipients live in rural areas or central cities (1998). A study conducted in **Boston** found that since 1970, job growth has been concentrated in the suburbs. Specifically, this study indicated that about 70% of the jobs in manufacturing, retailing, and wholesaling -- sectors employing large numbers of entry-level workers -- are now located in the suburbs. Just 32% of potential employers (those companies located in high-growth areas for entry-level employment) were within one-quarter mile of public transit (GAO, May 1998).

Schedules and routes for public transit systems are designed to bring employees living in the suburbs to their jobs in the city, not the reverse. According to a November 1997 city survey by the U.S. Conference of Mayors, respondents noted problems getting to jobs due to inadequate local bus schedules, affordability of bus passes, lack of public transportation routes to the main industrial centers, long commutes, and safety issues around bus stops and other areas. The transportation barrier is magnified for low-income Americans living in rural counties, 40% of which have no public transportation services. Yet, one in four families receiving public assistance live in rural areas where the rate of unemployment is higher than in cities (NTRC, 1997).

Since few welfare recipients own cars, private vehicle ownership does not offer a solution to getting to work for many people. In the past, the actual number of recipients owning cars was probably under-reported due to the very strict limitation on vehicle allowance imposed for AFDC eligibility. Although there is question of the accuracy of a 1997 HHS report that less than 6% of welfare families had a car in 1995, the correct percentage is still probably a distinct minority. Another 1997 study, found that car ownership by welfare mothers ranged from 20 to 40% (GAO, May 1998).

Where public transit exists, train schedules and hours may not match work schedules. Many entry level jobs require evenings or weekend hours in areas with few or no scheduled runs at those times. Many parents going to work also need transportation to access child care, which further complicates getting to and from work. It may not be practical, or even possible, to make a series of public transit trips to drop children off at child care or schools, go to work, pick-up the children, and stop for groceries on the way home.

Scattered Efforts to Address Transportation Problems

A recent report by the Community Transportation Association of America identified 90 programs across eleven federal departments and six independent federal agencies which can be used to support community transportation efforts in planning, capital purchase and operating services (HHS, Dec. 1998). Many of the programs instituted through these funding sources serve a limited geographic area or a select population with low numbers of actual participants and are time limited. Yet as research and demonstration projects, these program experiences can identify programmatic and demographic factors that local transportation and welfare officials should consider to ensure the more effective transportation strategies are employed to support welfare reform (GAO, May 1998).

JOBLINKS is one of the existing pilot programs funded by the Federal Transit Administration (FTA) since 1995. With \$3.5 million in funding, the purpose of this program is to help people obtain jobs or attend employment training, and to evaluate which types of transportation services are the most effective in helping welfare recipients get to jobs. As of March 1998, JOBLINKS had funded 16 projects located in urban and rural areas in 12 states; ten projects were completed and six were ongoing.

JOBLINKS has not always achieved its broader program objectives. An express bus from inner-city **Louisville, KY** to an industrial park reduced the commuting time from two hours to 45 minutes, but still did not reach the goal of a 25% increase in new-hires from the inner-city area. A **Fresno, CA** project provided transportation services to employment training centers to encourage participation and subsequent employment. Yet, of the 269 participants in a job training program, only 20 had completed the program and three had found jobs (GAO, May 1998).

In late 1996, the Department of Housing and Urban Development (HUD), began a four-year research demonstration program with \$17 million in public and private funding. HUD's Bridges to Work program is intended to link approximately 3,000 low-income, job-ready, inner-city residents with suburban jobs in five cities (**Baltimore, Chicago, Denver, Milwaukee, and St. Louis**). The program is designed to determine whether the geographic separation of jobs and low-income persons could be overcome by the coordinated provision of job, transportation, and support services.

Through March 1998, the Bridges to Work program had placed only 429 low-income, urban residents in suburban jobs (GAO, May 1998). According to the project's sponsors, the number of placements has been low in part because the program accepts only job-ready applicants -- a criterion that limits the number of eligible participants when unemployment rates are low and most job-ready people are already employed. Access to the program is further restricted by the requirement that no more than one-third of the participants can be former AFDC recipients. Yet, the program has proven to be moderately beneficial to some. Early results show that about three-quarters of the participants who found jobs were paid between \$6 and \$8 per hour and the same number have reasonable commute-to-work times of a half-hour to an hour (GAO, May 1998).

Although results may be less than hoped for, evaluations of the JOBLINKS program, reports from

Bridges to Work program managers, and past research on other initiatives have identified successful strategies for implementing transportation programs that support welfare-to-work. These programs have demonstrated that improving access to transportation alone is not sufficient if other barriers to work are not addressed. Also, the transportation offered has to be flexible enough to accommodate a variety of hours and locations without creating such long commutes that the low wages do not warrant the substantial time investment. Preliminary results indicate the need for: (1) collaboration among transportation, employment, and other human services organizations; (2) an understanding of employment needs of local job markets; and (3) flexible transportation systems (GAO, May 1998).

Options to Make Transportation Available to More Poor Families

Despite the array of demonstration programs in the last few years, public transportation still is not available to many families trying to leave welfare for work. Both Temporary Assistance to Needy Families (TANF) and Welfare-to-Work (WtW) provide access to new funds for states to address transportation barriers. The funding sources allow for very individualized, flexible transportation responses which can benefit a whole community. Funds can be used to reimburse expenses related to operating a personal car or for transit passes on transportation systems. Existing transit services can be expanded or where no such systems exist, funds can be used to purchase vans or minibuses to run special routes.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) allows a state to use both its federal block grant money for TANF and the required state maintenance-of-effort (MOE) funds for transportation¹. The U.S. General Accounting Office estimated that if all states received their full-year TANF allotment in 1997 and maintained state funding at 80% of historic levels (as required), they would have had about \$4.7 billion more than they would have spent in 1997 under prior methods of financing (GAO, June 1998). In fact, by the end of FY'98, approximately \$3 billion in federal TANF funds for FY'97 and FY'98 combined were left unexpended and unobligated (Falk, 1999). Many states wish to leave some TANF funds in reserve for periods of economic downturn, when TANF caseloads can be expected to increase, but policy makers also realize that assisting families to permanently leave welfare can reduce future welfare expenditures.

States can use federal TANF funds to provide necessary transportation services directly to TANF-eligible families, or to fund services available to other low-income families, but that primarily benefit eligible families. For example, funds can be used to reimburse TANF-eligible families for work-

¹ For a state to receive its full TANF block grant allocation, it must meet an 80% MOE requirement (or 75% if the state meets the work participation rate requirement). The MOE level is based on a state's FY 1994 spending on the welfare programs replaced with TANF and CCDF. A state can use dollars that count towards its MOE for transportation expenditures for families in TANF funded programs, and for "eligible families" that meet the state's TANF income and resource standards, but may not meet some other TANF requirements, thus are being served through a separate state funded program. Expenditures for transportation assistance from MOE funds are not restricted to employment-related activities, but also can be used for participation in education and training programs (Greenberg, 1998 and HHS, May 1998).

State Transportation Initiatives

Using TANF and WtW funds and other monies, a number of states are adopting a wide range of strategies to address the transportation needs of people transitioning from welfare to work.

Enhancing Public Transportation

Contracts for linkages to existing public transit (shuttles, mini-buses, car pools)

New York's Hublink transportation plan coordinates MetroBus and Rail systems with mini-buses and vans that operate under contract with local governments. These smaller vehicles provide transportation in areas where conventional bus service is economically infeasible. Hublink's essential components are a network of vehicles providing links to transit hubs, dial-a-ride services, and coordination between agencies. A number of other states, including Kentucky, also provide contracts for transportation linkage services.

Purchase of vans/minibuses by state or locale for alternate transportation routes

Wisconsin developed its Job Ride program in response to the fact that few families receiving public assistance own cars. By creating a van pool program, this program seeks to link transportation-dependent, low-income job seekers with jobs in outlying areas not traditionally served by fixed routes. Over the last eight years, Job Ride has recorded more than 72,000 trips to work.

Transportation during off-service hours

The area agency on aging in Pine Bluff, Arkansas, in collaboration with a transportation provider and a local JOBS agency, transports unemployed residents to employment centers. In order for more workers to access these centers and to better coordinate transportation throughout the county, the program offers expanded hours of its current subscription service. Michigan and Oklahoma are among other states that also provide programs to expand the hours of transportation services.

Purchase of passes or vouchers on a public or private transit system

In Detroit, Michigan, the local suburban transportation provider, SMART, uses free passes to market its transportation services to job seekers and the recently employed. SMART redesigned its services and routes to provide access to jobs for unemployed inner-city residents. This program is funded by federal Joblinks program. The New Jersey Department of Transportation funds a program that provides one month of free public transportation to any individual leaving assistance for employment that is accessible by public transportation.

Improving Access to Private Vehicles

Donation and repair of previously owned vehicles

The Wheels-To-Work program in Forsyth County, North Carolina provides reliable and affordable vehicles to individuals without access to public transportation for one year so that they can acquire and maintain employment. With the aid of donations, Goodwill Industries reimburses the initial cost of liability insurance, repairs, taxes, license and title fees. Throughout the year, the individual is required to make monthly payments

to Goodwill and take responsibility for monthly maintenance of the vehicle (oil, fluid, repairs) at local car dealerships offering discounts. Other states which also participate in vehicle donations and repair programs include Texas, Florida, and Pennsylvania.

Financial assistance for lease or purchase of a vehicle by eligible individuals

Through its Big Sandy Vehicle Leasing Program, Kentucky offers a vehicle leasing program for residents within three months of securing employment and receiving state assistance or participating in a state job training program. Participants pay \$30 per month while searching for employment and \$60 per month after the first month of employment. Once employed, the lessee can lease the vehicle for a maximum for one year and must agree to car pool other Kentucky WORKS participants in need of transportation.

Loans for individual transportation needs

Banks and social service agencies in California administer loans to families for private transportation needs. Loans provide money to pay for used cars, auto insurance, and car repairs. The loans are backed by donations from the Peninsula Community Foundation, the David and Lucile Packard Foundation, and the McKnight Foundation. Other states, like Minnesota and Ohio, also offer loan programs.

Full or partial reimbursement to individuals for work-related transportation

As part of Tennessee's Department of Human Services' contract with Job Training Partnership Act agencies for transportation brokerage services, brokers often work with local gas stations to provide gasoline vouchers. These vouchers enable participants using their own transportation to attend training sessions and interviews with no out-of-pocket expense. Tennessee has employed this strategy in addition to other transportation approaches such as car repairs and the utilization of school buses for transportation.

Other Innovations

Flexible funding for new or expanded transportation services

As part of Virginia Department of Social Services' allocations in 17 communities to pay for special transportation efforts, Fairfax County received \$345,394 to purchase minibuses and free taxicab rides in 1998. This state funding also helped counties assist welfare recipients purchase cars, develop a system with cab and gas companies to provide services, link rural regions to the main transit line to increase transportation flexibility, and begin other initiatives. Funding for and participation in such initiatives has come from private businesses, the state Department of Transportation, community action agencies, the faith community, and volunteers.

Incorporating other support services

In Ohio, Building Responsibility, Equality, and Dignity (BREAD) lead a campaign to build transit centers that provide transportation to low-income constituents in downtown Columbus. Transit centers not only serve as a transportation hub, but also provide a day care facility, classrooms for job training and other community activities, and a transit scheduling system. Complementing these initiatives, the Central Ohio Transit Authority (COTA), established bus routes between downtown Columbus and several suburban job sites to help facilitate transportation for low-income individuals based on negotiations with BREAD.

Sources: National Transit Resource Center, Access to Jobs (1999) and Transportation and Welfare Reform: States on the Move (1997), Community Transportation Association of America, Washington, D.C.

related transportation expenses like gas, public transit fare, or auto insurance or to contract for shuttles, buses, or car pools linking poor workers to previously inaccessible jobs. TANF funds have been used, indirectly, to fund transportation by the 35 states that have raised the vehicle allowance for TANF eligibility to \$7,500 or higher, or simply allow ownership of one vehicle regardless of value (Venner & Brown, 1999).

The Balanced Budget Act of 1997 also provided \$3 billion over two years for formula and competitive Welfare-to-Work grants (WtW) to pay for a variety of employment-related activities aimed largely at individuals on welfare facing significant work barriers. To access formula grant funds, a state must provide \$1 in matching funds above its TANF maintenance-of-effort level for every \$2 it receives. Although initial funding was only for FY'98 and FY'99, the President's FY 2000 budget proposal includes \$1 billion to extend the Welfare-to-Work grants for a third year.

WtW funds used for transportation services are limited to eligible individuals engaged in "allowable activities" and only for services "not otherwise available to the participant" (HHS, Dec. 1998). In spite of these restrictions, most state plans for WtW grants include transportation assistance with some providing bus passes, and others developing collaborations to come up with more comprehensive strategies to address transportation needs (Reichert, 1998).

When assessing the potential of existing transportation, the search need not be limited to that which is provided by public transit authorities or privately owned vehicles. States are increasingly recognizing that the use of alternative vehicles is one of the most economical ways of getting welfare recipients to jobs and other destinations. Among the strategies for utilizing non-public transportation supported by TANF and WtW funds are the following:

- Although a community may not be served by city buses or commuter trains, utilizing school buses and vans for senior citizen centers or Head Start programs may be feasible since these vehicles generally are not used during off-hour commuter times that many welfare recipients work. Tapping into these resources requires non-traditional collaboration but not unsurmountable barriers. The issue of insurance coverage for liability must be addressed but it should not be a problem unless a statement in an agency's transportation policy requires that a vehicle not be used for other purposes than the one specified. Agencies that want to coordinate transportation can add a rider to an existing policy, extend an existing policy, or create a new insurance policy to cover expanded services (Kaplan, 1998).
- The Charitable Choice provision in PRWORA also allows TANF funds to be paid to charities, religious groups and other private organizations to provide services such as transportation. Some states have contracted with congregations to use their vehicles when they are not in use by the religious institution.
- With three out of four welfare recipients living in rural areas or central cities with no transportation to the jobs in the suburbs, sometimes a private vehicle is the only answer to make the link between home and work. TANF allows for financial assistance in the form of loans to eligible individuals to lease or purchase a car. A revolving fund where recipients are given interest free loans to buy or lease a car is a way to sustain available funding. WtW funds

can be used by a sponsoring agency to purchase vehicles that can be loaned to individual workers or for car pools.

New Funding for Flexible, Targeted Responses to Transportation Need

With the enactment in June 1998 of the Transportation Equity Act for the 21st century (TEA-21), creating the Job Access and Reverse Commute grant program, new funds for transportation are now available. Funding is authorized at \$150 million per year for fiscal years 1999 through 2003, with \$75 million actually appropriated for FY'99. No more than \$10 million per year is to be used for reverse commute projects. The program is expected to leverage other local funds that are eligible to be expended for transportation. The first round of competitive grants for regional approaches to increase the availability of transportation to work were awarded in March 1999.

EMPOWER Kentucky: A Comprehensive Transportation Initiative

In a state where 22 rural counties have no public transportation, Kentucky announced a transportation delivery process under the EMPOWER Kentucky plan in 1997. This plan guarantees transportation service to all welfare recipients for trips related to employment and child care. In addition, the plan includes transportation for all non-emergency medical trips for Medicaid recipients. Prior to this plan, Medicaid recipients received vouchers for medical transportation and TANF recipients received a \$3 per day cash payment mailed directly to them.

Under AFDC, Kentucky fully exempted welfare recipients in 28 counties from work or job training activities because of a lack of access to transportation or insufficient job opportunities. With its new transportation initiative, Kentucky hopes to incorporate these areas into a coordinated transportation system as a way to facilitate getting welfare recipients back to work.

Kentucky divided the state into 16 multi-county regions based on the number and size of existing transportation providers, as well as the number of potential TANF and Medicaid consumers. After a trial period in one of the pre-determined regions, Kentucky is now in the process of implementing this program in all of the 16 areas. Kentucky's goal is to have all regions participating by the end of June 1999, to serve its approximately 56,000 TANF recipients and 520,000 Medicaid recipients.

EMPOWER Kentucky seeks to contract with a single provider/broker in each region. Each provider is responsible for directly providing or securing a means of transportation to consumers in the region. Providers/brokers are paid a flat, or capitated, rate which the state plans to evaluate after a couple of years. Providers currently include non-profit transit brokerages, pure brokers who subcontract out services, and private brokers (mainly taxis). These providers/brokers use taxis, for-profit public transportation systems, or disabled person transit vehicles to provide transportation services.

(See previous textbox for additional transportation programs in Kentucky)

The goals of the program are to provide transportation services in urban, suburban and rural areas to assist welfare recipients and low-income individuals to access employment opportunities, and to increase collaboration among the transportation providers, human service agencies, employers, metropolitan planning organizations, and affected communities and individuals. Access to Jobs projects target families whose income are at, or below, 150% of the poverty level and focus on implementing new or expanded transportation services to transport people to and from jobs and employment-related services like child care. Access to Jobs grant money may be used for promoting services and financing capital and operating costs that respond to transportation needs by such means as adding late night and weekend service, providing guaranteed rides home, initiating shuttle service, providing demand responsive van services, and sponsoring ridesharing activities (DOT, 1998).

While Access to Jobs grant money can be used for adding buses, trains, car or van routes or services, it can not fund transit passes (TANF and WtW funds can be used for this). Also, although TANF and WtW funds can be used for loans for private vehicle ownership, vehicles acquired with Access to Jobs funds must remain under the control of the agency receiving the grant (DOT, 1998).

The Job Access and Reverse Commute program requires a cost share of at least 50% of the project's total cost. However, the program has the unusual feature of expressly allowing funds from other federal programs, that can be expended for transportation activities, to be used for the local match. Therefore, TANF funds and WtW grant funds can be used to meet the cost share requirement. Limits imposed on TANF funds, and similarly for WtW grants, restrict their use to: (1) new or expanded services, (2) services primarily for the benefit of current, former, or at-risk of being TANF recipients, and (3) services promoting the ability to engage in work activities. Receipt of services through TANF or WtW funds does count as TANF "assistance" as previously discussed, but if the transportation benefit is the only form of assistance provided to the individual for a month, then it is not considered "assistance" for purposes of applicable TANF programmatic requirements (HHS, Dec. 1998).

See the "References and Resources" section of this report for identification of references cited in this section.

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State Investments to Make Work Feasible

Filling the Health Care Benefits Gap

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FILLING THE HEALTH CARE BENEFITS GAP

Why the Poor Lack Health Care Coverage

Despite low unemployment and increased economic growth in recent years, the number of uninsured children increased from 10 million in 1995 to 11 million in 1996, or 15% of all children, according to the Census Bureau's Current Population Survey (CPS). More than two-thirds of uninsured children come from low-income families, and the majority of these children have at least one parent who works full time (CBO, 1998). Many more children have parents who hold "non-standard" jobs (i.e., temporary, part-time, seasonal), which seldom include health care coverage. The percentage of children covered by private health insurance decreased every year from 1987 through 1994, until recently leveling off (GAO, 1996).

Children living in the South and Southwest are much more likely to be uninsured than those living in the rest of the country (CBO, 1998). These disparities are even more stark when comparing individual states. **Massachusetts, Michigan, Minnesota and Wisconsin**, for instance, have only 5 to 6% of their children uninsured, compared to the 19 and 21% uninsured in **Mississippi and Texas**, respectively¹ (Brennan et al, 1999). Adults fare even worse overall and across states. Seventeen percent of all non-elderly adults were uninsured as calculated by Urban Institute. The percentage varied from 9 to 11% in **Massachusetts, Michigan, Minnesota and Wisconsin** to 27% in **Texas** (Zuckerman & Brennan, 1999).

The percentage of uninsured adults is higher when only taking into account low-income workers. According to 1997 Census Bureau data, 46% of working poor parents lacked health insurance. The states with fewest numbers of of working poor uninsured parents are **Hawaii** (15.6%), **Nebraska** (20.6%), and **Wisconsin** (24.1%). At the other end of the spectrum, are **Arkansas, Arizona, New Mexico, and Texas** with more than 60% of working poor parents uninsured (Guyer & Mann, 1999).

Past studies have shown that poor families sometimes turned to AFDC because they had no other way of accessing health insurance for themselves and their children. Either it was not offered by the employer or the family could not afford the co-payment. A national survey of employers with large numbers of entry-level jobs affirms the problems encountered. It reports that less than half of the employers offer health benefits, and only 6% provide coverage immediately; among employers offering health benefits, one-quarter cover 50% or less of the cost (Regenstein et al, 1998). Even at businesses where benefits are offered at an affordable level, many entry-level employees never get to take advantage of them because of high turnover combined with lengthy waiting periods for eligibility.

¹ Based on a belief that CPS undercounts Medicaid enrollment and, therefore, overstates the number of uninsured Americans, the Urban Institute estimates that 12% of American children were uninsured in 1996, not 15% as reported by CBO (Ullman et al, 1998; Brennan et al, 1999). The state rates of uninsured children and adults cited here are based on the Urban Institute's calculations.

Parent perception that publicly financed health insurance is the only way to get coverage for their child is not unfounded. The majority of working parents with uninsured children do not have access to employer coverage. Forty percent of these parents work for employers who do not offer insurance and another 15% are not eligible for their employer's insurance (Families USA, 1998). Of the 9% of families who decline employer-sponsored insurance when it is offered, almost 85% do so because they could not afford the employee's share of the cost (Families USA, 1998).

Indeed, for low-income families who are left to purchase health insurance on their own, the costs can be prohibitive. For families without access to employer-subsidized insurance, the average annual premium cost for family coverage was \$5,188 in 1996, or about \$432 per month (Families USA, 1998). This excludes co-payments for doctor visits, uninsured services such as dental and vision care, and deductibles for hospital care. For families at the poverty level, premium costs alone would constitute one-quarter to one-third of their income. Studies show that few uninsured families believe they can justify purchasing health insurance if the cost is more than 5% of family income (Families USA, 1998).

Medicaid's Role in Insuring Poor Families

Efforts to Preserve Eligibility

Although the American public has been hesitant to support a national health care program, when explicitly asked if government should provide health insurance for uninsured families the majority express support. Sixty percent of the respondents in a 50 state telephone survey believed persons who cannot afford health insurance or whose employers do not provide it, should have health insurance paid for by government/taxes. When the question is re-phrased to ask about coverage for just the children in those families, support for government/tax supported health insurance increased to 78% (Kellogg, 1999).

Medicaid is the long-standing federal and state government program that provides health care coverage for poor families. The federally covered portion of Medicaid expenditures ranges from 50 to 77%, depending on a state's economic status. Traditionally, Medicaid was only available to families who were receiving AFDC (unless they had eligibility through another program, such as SSI). The Family Support Act of 1988 partially addressed this lack of coverage for the working poor by extending eligibility for Medicaid benefits for up to 12 months to families who lost AFDC eligibility because of earnings. Additional changes to the Medicaid program with the passage of the PRWORA of 1996 opened the door for greater expansion to poor working parents.

The major change in 1996 was "delinking" eligibility for family cash assistance and Medicaid².

² The 1996 federal welfare law also instituted some other changes that impact receipt of Medicaid. Sixteen states reported the intent to exercise the new option to withhold Medicaid for adults as a sanction for noncompliance with TANF work requirements (CHN, 1998). Also, most legal immigrants who entered the country after August 1996

Formerly, AFDC eligibility automatically made a family eligible for Medicaid. By removing the entitlement for AFDC and replacing funding within the block grant for TANF, the new law left eligibility for cash assistance to the state's discretion. To maintain a national standard for Medicaid eligibility, the new law stipulated that children and parents whose income and assets were in accord with the AFDC eligibility criteria in effect in their state in July 1996, would qualify for Medicaid regardless of whether they were eligible for the new cash assistance program under TANF³.

The 1996 law also continues transitional Medicaid (TMA) benefits for up to 12 months for low-income families leaving welfare for work. Under the new law, states also can extend eligibility by increasing the income and resource limits by as much as the consumer price index (CPI) rises or by using less restrictive methods for calculating family income and resources. These expansions of benefits will be discussed in more detail in a later section.

Reasons for Enrollment Decline

Although the downward trend in private health insurance coverage has subsided, the ranks of the uninsured continue to swell. While in recent years federal law has created provisions to make more poor families eligible for Medicaid, enrollment has actually declined. Since August 1996, when the federal welfare law was signed, Medicaid enrollment has declined by 8% (CA, NJ) to 15% (TX) in several of the most populous states⁴ (Pear, 1999). State studies of families no longer receiving AFDC/TANF have found that Medicaid enrollment falls after families leave welfare. Reports on the wages parents receive do not indicate that they are losing Medicaid because their earnings are too high. Also, the reduction in Medicaid enrollment when families leave AFDC/TANF significantly exceeds the numbers reportedly receiving employment-based health care coverage (NGA, 1998 & Kaiser, 1998).

Although there is insufficient documentation, the national decline in Medicaid enrollment is attributed to several factors -- failure to identify individually eligible family members, lack of awareness of continuing benefit eligibility both on the part of the caseworker and the family, other agency errors, a mistaken belief by recipients that all assistance (including Medicaid) is time limited, and the general discouragement of the poor from seeking any type of public assistance. A large part of the caseload decline may be attributable to fewer families entering TANF and more being terminated due to sanctions. With the delinking of Medicaid and TANF eligibility, most families who formerly would

are now only eligible for emergency services under Medicaid. States have the discretion to decide whether or not most legal immigrants who were already in the country will be eligible for the full range of Medicaid coverage.

³ In some cases, the provision tying eligibility to the July 1996 level allowed states to keep more generous income and resources limits for Medicaid eligibility than the standard AFDC limits, because of relaxation of these limits allowed through the HHS waiver process prior to July 1996.

⁴ Other reported declines in Medicaid enrollment during this period include **New York** - 9%, **Oregon** - 11%, and **Pennsylvania** - 13% (Pear, 1999).

have been receiving cash assistance are still eligible for Medicaid but may not be applying or are wrongly discontinued.

With eligibility for Medicaid delinked from TANF eligibility, many administrative precautions must be taken. To date, all states appear to have maintained a joint application procedure for TANF and Medicaid (Schott & Mann, 1998). While many states are trying to divert families from TANF or quickly move them off welfare, the same reasoning cannot and should not apply to Medicaid. Ensuring that families can receive Medicaid coverage without also receiving TANF cash assistance can actually bolster states' welfare avoidance efforts. If states wish to avoid errors that could inappropriately terminate Medicaid coverage, they should:

- Ensure that applicants understand that Medicaid is available to families that do not receive TANF benefits and the application should continue to be processed for Medicaid even if it is not for TANF. If there are requirements that have to be met (e.g., job search) before an applicant can apply for TANF, these must not delay the Medicaid application. If a state has a diversion program for TANF, as long as the diversion payment is disregarded as income or an asset, receipt of the diversion payment is not a barrier to Medicaid eligibility.
- Ensure that a withdrawal from the TANF application process or benefits is not treated as a withdrawal from the Medicaid application process or termination of Medicaid benefits. If a parent asks to voluntarily have her TANF case closed, this should not automatically close the Medicaid case. Federal Medicaid rules require that any voluntary request to stop Medicaid be in writing and be confirmed in writing by the agency.
- Inform applicants denied Medicaid for failure to provide information, that they have a right to re-open the application at any time.

Transitional Medicaid for Families Leaving TANF

When a family loses eligibility for TANF benefits due to earnings, they may retain eligibility for transitional Medicaid (TMA). The 1988 Family Support Act required states to extend Medicaid coverage for up to 12 months to families who lost AFDC eligibility due to increased earnings, and PRWORA continues this obligation. The family retains eligibility for TMA as long as there is still a dependent child in the home, other requirements are met, and the family's average gross monthly earnings, less allowable child care costs, does not exceed 185% of the federal poverty level (Kaplan, 1997).

It was estimated by some researchers that only 20 to 30% of all former AFDC recipients were enrolled in TMA (Kaplan, 1997). The data on the number of uninsured adults who recently left TANF indicated that even fewer may be making use of TMA now. If recipients are unaware of TMA benefits, the program does not remove the disincentive for work as it was intended, nor does it make affordable health care available for those who need it. It is estimated that 10 to 11% of adult welfare

recipients have serious, chronic health conditions that may require ongoing treatment (Pavetti, 1996). Lack of adequate health care for newly-employed welfare recipients increases the likelihood that they will experience higher absenteeism, poor productivity and poor job retention, as well as risk the worsening of their health status (Kaplan, 1997).

Several states have recognized the importance of TMA and sought to extend this benefit through waiver authority prior to the passage of the 1996 federal welfare law. Twelve states (AZ, CA, CT, DE, NE, NJ, RI, SC, TN, TX, UT, VT) continue to provide TMA benefits beyond the 12-month period through the continuation of a waiver. Extended benefits generally are for a duration of 18 months to 24 months, while **Vermont** extends TMA for up to three years. **Missouri** also has just received a waiver to extend TMA coverage for former welfare recipients who have exhausted their TMA coverage for two additional years, provided their family income is below 133% of the federal poverty level and there is a child in the home (Brown et al, 1998).

Changes Expanding Medicaid Eligibility for Low-Income Families

Until recently, states could not cover parents in two-parent families to the same extent that they covered parents in single-parent families without a federal waiver. In August 1998, HHS eliminated the regulations that primarily restricted this, thus allowing two-parent families to be covered by Medicaid to the same extent as single-parent families. As of the fall of 1998, 29 states and the **District of Columbia** had dropped the limitations on covering parents in two-parent families (Guyer & Mann, 1999).

The provision in PRWORA that delinked Medicaid eligibility from TANF (Section 1931) also created the opportunity to expand Medicaid to low-income working parents through broad flexibility accorded states to define what counts as income and resources when determining eligibility. When calculating *countable* income and resources, federal law requires states to disregard a certain amount. For example, states are required to disregard \$90 in earnings each month to help parents cover expenses associated with working. Section 1931 allows states to liberally expand this income disregard and the state can opt to eliminate the resource (asset) test altogether.

Rhode Island and the **District of Columbia** already have taken advantage of the working families Medicaid expansion opportunity. As a result of these expansions, low-income working parents can be employed full-time at jobs that pay up to \$12 an hour in Rhode Island and up to \$13 an hour in the District of Columbia, and still be eligible for Medicaid. In both programs, coverage is available to single and two-parent families and neither program requires families to meet a resource/asset test to be eligible for coverage (Guyer & Mann, 1999).

While some states have taken positive steps to provide more working parents with health insurance through Medicaid, many have not. Some 43 states do not cover working parents who earn enough to bring them just to the poverty level; in half of the states, working parents are ineligible for Medicaid if their earnings exceed 59% of the poverty level (Guyer & Mann, 1999). National and

Basic Medicaid Benefits

Services Covered: Federal provisions for Medicaid require states to offer a minimum package of services to eligible beneficiaries. For adults, this includes inpatient and outpatient hospital services, physician visits, laboratory and x-ray services, some clinic visits, very limited dental services (e.g., surgery but not fillings), nursing facilities or home health care for people over 21, and family planning services. Other services are optional but, if provided, get the same rate of federal reimbursement as the required services.

In addition to the above services, children up to age 21 are covered under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The basic preventive services under EPSDT include comprehensive physical and mental health screening, and vision, dental, and hearing services. Under EPSDT, all medically necessary services that are federally allowable must be covered, including optional Medicaid services that are not covered under the state's Medicaid plan.

Families Contribution: States may charge only nominal amounts for Medicaid premiums and service co-payments. Some beneficiaries, including pregnant women and children, may not be charged at all.

local efforts must intensify to make providers and parents more aware of Medicaid eligibility. In 1997, working parents were still uninsured at twice the rate as their unemployed counterparts (Guyer & Mann, 1999).

Health Care Coverage Expanded to More Poor Children

New Provisions Make More Children Eligible

Even prior to the 1996 welfare reform, a significant number of children -- 3.4 million -- were eligible for Medicaid but not enrolled. This means that 23% of children who were eligible for Medicaid were uninsured by either public or private coverage (GAO, Feb. 1998). Studies have shown that uninsured children are less likely than insured children to get needed health and preventive care. These children are less likely to get care for injuries, see a physician if chronically ill, get dental care, or be appropriately immunized to prevent childhood illness (GAO, 1996). Congress recognized the cost effectiveness of providing children with basic health and preventive care and passed a series of laws that expanded Medicaid eligibility to poor pregnant women and children. By July 1991, the requirement for Medicaid coverage was extended to include pregnant women, infants and children up to 6 years old with family incomes at or below 133% of poverty, and children six and over with family income up to the federal poverty level. Each year the age of eligibility for the latter rises and will reach children up to 19 years old by the year 2002. States were permitted to institute a faster phase-in and to raise the income eligibility level, and many have.

The Balanced Budget Act of 1997 (BBA) expanded the option for states to provide child health assistance to uninsured, low-income children with the creation of the child health block grant offering states \$20.3 billion over five years. The goal for the block grant funds is to significantly reduce the number of uninsured children with meaningful, affordable coverage. With the block grant funds, states are to initiate *child health insurance programs (CHIP)*, either by expanding coverage of children under the Medicaid program or creating\expanding separate child health insurance programs.

- If a state opts to expand coverage under the Medicaid program, it would do so by increasing its income eligibility standards or maximum age limit to cover children who did not qualify for Medicaid under state rules in effect as of April 15, 1997. Therefore, if a state had not extended coverage to children over age five or children with family incomes above 133%, it could increase the upper age limit or the income cutoff point, or both, so more uninsured children are eligible for coverage. Unless the state previously obtained a waiver to provide even more extensive coverage, the law allows for children under age 19 living in families with incomes under 200% of poverty to be included in CHIP. If a state uses some or all of its block grant funds to cover more children under the Medicaid program, Medicaid rules relating to entitlement, benefits, cost-sharing and delivery of services would apply to the newly covered group of children, just as the rules apply to other children served under Medicaid. (See textbox on "Basic Medicaid Benefits").
- States also can use block grant funds to establish or expand a separate child health insurance program. If the state chooses to do so, it cannot substitute this program for existing Medicaid coverage. To prevent this, the law denies the new child health funds to states that lower their Medicaid eligibility standards for children below their June 1997 levels. In a separate CHIP, states have broad flexibility to determine which children to cover. States may distinguish among children based on age, the length of time they have resided in the state, or whether they have access to other health coverage. The state can also control intake by imposing time limits for coverage, limiting enrollment to a certain number of children, and creating waiting lists if more children apply.

For the first three years of the block grant, each state's allocation is based on its share of the nation's uninsured children with family incomes below 200% of the federal poverty level. The state can expend federal funds up to a block grant allotment based on an "enhanced" Medicaid matching rate. The regular federal matching rate of 50 to 77% for Medicaid is "enhanced" to a federal share of 65 to 85% depending on the state's need. The same matching requirements apply regardless of whether a state uses its child health funds to create or expand a separate state program or to expand coverage under Medicaid.

State Choices Limiting CHIP Accessibility

Several arguments have been made that, from the perspective of the family, it is preferable for a state to choose to expand Medicaid coverage rather than create a separate state program for CHIP. This

Children's Health Insurance Program (CHIP) Implementation: A Review of State Approaches

The Children's Defense Fund's (CDF) *CHIP Checkup: A Healthy Start for Children* reviews 43 states that "completed state legislative activity around CHIP implementation or submitted plans to the Health Care Financing Administration (HCFA) for approval" by April 30, 1998. CDF rates states in four categories -- eligibility limits, affordability, benefits, and family friendliness. Below, the ratings have been used to illustrate the methods states have chosen to implement CHIP expanded Medicaid or separate state programs, as well as hybrid programs.

Some states, like *Connecticut and Missouri*, received high ratings in all four categories.

Connecticut's implementation of CHIP through a separate state program rated high in all categories. For those children under 18 not eligible for the expanded Medicaid program or not covered under another group health plan, Connecticut's HUSKY B program offers insurance for children under 300% of poverty. Premium costs for this program are based on a family's level of poverty. For those families up to 235% of poverty, there are no family premiums. For those between 235% and 300% of poverty, the program charges a \$30 a month fee for one child and \$50 a month for two or more children. Families above 300% of poverty can buy coverage by paying full premium costs.

HUSKY B requires a co-payment of \$5 for physician visits (except for well-child care and immunizations), and vision and hearing exams. Services also include detoxification, durable medical equipment, basic dental care, rehabilitation, and ten mental health visits with no co-payment. There is a \$650 maximum annual premium and co-payment cap for families between 185% and 235% of poverty, and a \$1,250 cap for those between 235% and 300% of poverty. In addition, the HUSKY Plus program covers services for children with special needs not met under HUSKY B such as family support, case coordination, and advocacy.

Connecticut's HUSKY B program has a simple application process, a toll-free number, 12-month continuous coverage, and children within a family are not forced into different programs based on age.

In Missouri, the expanded Medicaid program covers children through age 18 who are members of households with incomes up to 300% of poverty. To be eligible for this program, parents must cooperate with the pursuit of third party liability insurers, child support, and must show proof of vaccination and annual physical examinations. Family premium costs, co-payments, and benefits all follow Medicaid rules. (See textbox on "Basic Medicaid Benefits".)

The program's family-friendly components include the fact that applicants are only required to fill out one mail-in application and that the program provides one program for all children in a family. In addition, there are increased access points for eligibility determination.

Some states, like *Pennsylvania*, have liberal eligibility and low consumer costs, but limited benefits and are less user friendly.

Pennsylvania administers a separate state program for children ages one through 18 from households up to 235% of poverty. Households up to 200% of poverty pay no premiums and families between 200% and 235% of poverty pay 50% of full premium costs, as premium costs vary based on the provider chosen. There are no co-payments for those enrolled in Pennsylvania's program.

Although durable medical equipment, hearing aids, and preventive, routine and emergency dental care are covered, many services are provided on a limited time basis. Inpatient care, mental health, vision care, and rehabilitative therapy all have limits on the number of days services can be provided. This program also provides no substance abuse treatment, orthodontics, maternity benefits, or rehabilitation services for a developmental disability.

Since different children within a single family can be enrolled in different programs, parent must work with multiple programs. Although there is a combined, simple application, each private insurance contractor maintains its own outreach efforts.

Some states, such as *Texas*, have very limited eligibility and high consumer costs, but provide liberal benefits and are user friendly to those who qualify for the program.

Texas' expanded Medicaid program simply accelerates coverage for children aged 14-18 with a family income up to 100% of poverty, from the required implementation by 2002. Eligibility does not extend beyond the poverty level. For children who are eligible, premium costs, co-payments, and benefits follow fairly generous Medicaid rules.

Since all children in a family use one program, parents do not have to work with multiple programs. Enrollment requires a short, user-friendly form.

Some states, like *Montana*, received relatively low ratings in each category.

Montana created a separate state program for children through age 18 up to 150% of poverty. Families up to 100% of poverty are charged an annual enrollment fee of \$25 per child, with a family maximum of \$100. The program imposes a \$50 per child annual enrollment fee (\$200 family maximum) for those families between 101% and 150% of poverty. Participants in the program pay a \$3 co-payment for emergency room service, but there is no other point of service cost-sharing.

A number of services are not covered under Montana's plan, including durable medical equipment, dental care, hearing aids, eyeglass, medical transportation, home and community based care, and physical, speech and occupational therapy. Even in some provided components of the program, such as mental health care and substance abuse treatment, there are time limits for coverage.

Within a single family, different children can be placed in different programs based on their age.

avoids families having some children covered by Medicaid and some children covered under a state program. It may also avoid needing to change a child's coverage if there is a small shift in income. In addition, there is some benefit to the state to elect to expand coverage under Medicaid. It can avoid the need for, and cost of, duplicative administrative systems. Expanding Medicaid to create a CHIP also provides states with open-ended federal matching payments and greater protection against rising health care costs (Mann, 1997).

States have the option to impose premiums and cost-sharing on families participating in children's health plans. Only "nominal" out-of-pocket costs can be charged to families with incomes below 150% of poverty. For families with higher incomes, states can impose a sliding fee but total out-of-pocket costs are not to exceed 5% of family income. It appears that in all but two states, it is the family's responsibility to track whether this limit has been reached (Fox, 1998). Nine states (CA, CO, KY, MA, ME, NV, NY, TN, WI) are charging \$200 a year or more in premiums to low-wage working families eligible for CHIP, with the highest being Wisconsin at \$891 per year followed by Tennessee at \$786 (CDF, 1998). This may create a barrier for uninsured children to receive the coverage they need. High premiums and high co-payments are especially problematic for children needing special medical treatment. Given their elevated service needs, children with chronic conditions are more affected by co-payment requirements than other children. To address this, several states have adapted cost-sharing policies intended to minimize the financial burden on these families (Fox, 1998).

The Children's Defense Fund (CDF) analyzed the initial plans for CHIP submitted by each state, provided an overview of what they found, and rated key policy decisions (see textbox on previous pages). CDF found that of the 41 states proposing new income eligibility standards, 20 states cover children up to or even above the general CHIP ceiling of 200% of poverty; all but two states (OK, RI) cover children through age 18 (1998). On the discouraging side, some states with large numbers of uninsured children have only enacted limited expansion in the first year. For example, nearly one in six uninsured children live in three states -- Alabama, Mississippi, and Texas -- which have cut off eligibility at 100% of poverty (CDF, 1998). This may be because the law does not provide enough incentive to these states to extend their coverage. Lowest-income states, which tend to have the highest percentages of uninsured children, already have the most generous federal matching rates under Medicaid. Thus, the increase from a 77% federal match to 85% may not provide enough of an incentive to extend Medicaid eligibility to as many children as possible.

Options to Reach More Poor Uninsured Children

States' decisions not to provide the maximum allowable coverage are not based on a lack of available federal funding for CHIP. There are an estimated 2.9 million CHIP-eligible children in families with incomes under 200% of the federal poverty level (Ullman et al, 1998). Children eligible for CHIP represent about 40% of all uninsured children under 200% of poverty using Current Population Survey estimates of the number of uninsured children; using the Urban Institute's estimates for uninsured children the percentage increases to 60%. The average cost of coverage for children in the

CHIP-eligible population was \$1,030 per child in 1998. Based on this, the Urban Institute estimates that states will have the capacity to cover nearly twice as many children as they project to be eligible for CHIP, if all states increase coverage to children in families with up to the maximum income of 200% of poverty (Ullman et al, 1998).

In addition to providing coverage to all children who meet basic eligibility requirements, states could tap into these projected unused funds to cover even more uninsured children, for example:

- If prior to CHIP the state had already raised its Medicaid family income cap to over 150% of the federal poverty level, the law allows that state to increase the cap by an additional 50%. Therefore, if the cap had been 185%, it could be raised to 235%, making more poor children eligible for Medicaid coverage.
- States can adopt more liberal methodologies for evaluating income assets the same as they can for Medicaid for poor parents under PRWORA. A disregard of a substantial amount of earnings or raised asset limits would entitle more uninsured children to Medicaid coverage.
- States can avoid underutilization of CHIP by not instituting prohibitive premiums or co-payments and not requiring lengthy waiting periods for eligibility.

To increase awareness of eligibility and to help families enroll uninsured children in CHIP and Medicaid, the federal government and states are developing and implementing outreach strategies. The Clinton Administration has launched a nationwide "Insure Kids Now" campaign which includes a hotline (#1-877-KIDS-NOW) with state-specific information about CHIP and Medicaid. Statewide hotlines have been established or are planned in all states (Kauffman, 1999). To respond to parents' questions regarding the child health care coverage programs, many state hotlines will have extended hours of operation to accommodate working parents and will assist callers in completing the application form that is mailed to them. Additional state outreach efforts include distribution of materials through public schools, direct mailings to targeted groups, and multi-media coverage (Kauffman, 1999).

See the "References and Resources" section of this report for identification of reference cites.

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State Investments to Make Work Feasible

Investing in Child Care Assistance

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INVESTING IN CHILD CARE ASSISTANCE

Dilemma of Child Care for Welfare Recipients and Working Poor

The inability to access and afford child care has long been identified as a key barrier to employment by welfare recipients. Studies indicate that parental decision-making about child care is a complicated process that balances many competing criteria including financial cost and compatibility of child-rearing values, along with logistical considerations, such as convenient hours and location (Collins & Carlson, 1998). Generally it takes from two to seven weeks for parents to find acceptable child care (Kisker & Ross, 1997). Single mothers moving from welfare to work may not have the luxury to take the time and weigh these factors in the manner in which all parents desire.

Because so many of the jobs that welfare mothers obtain have erratic schedules -- part-time, before-school, after-school, evening, swing-shift, and weekend -- most women in a recent **Boston** area study reported that child care is seldom taken care of with one arrangement. It requires patching together help from family and neighbors, formal care, and sibling care (Dodson et al, 1998). Of course any of these arrangements can break down, and often do. One unreliable child care arrangement can be the difference between welfare and work. A 1990 study found that nearly one of every six mothers employed outside the home reported losing some time from work during the previous month due to a failure in their regular child care arrangements; even higher rates have been found for low-income mothers (Blank, 1996).

Lack of private transportation further complicates child care logistics. An estimated two-thirds or more of welfare recipients do not own a private vehicle. A national study found that only 40% of child care centers, and 28% of regulated family child care providers, were located near public transportation (Kisker & Ross, 1997).

The cost of child care is a major obstacle faced by all low-wage earning parents. For some leaving welfare for work, care by relatives is an option, as it is for 30% of low-income mothers, but frequently even this care is not free (Kisker & Ross, 1997). For poor families who have to pay full fare for child care, the costs are prohibitive. In 1997, average annual cost of care for a child in contracted programs in **New York City** was \$6,700 (McCall, 1997), in **Oregon** child care averages \$7,344 a year (Conway & Elliot, 1997) and in **Boston** it is \$7,904 (Dodson et al, 1998). A full-time worker at minimum wage earns only \$10,712 annually, an income which makes it prohibitive to cover such child care costs. In fact, a study based on 1990 incomes found that impoverished families purchasing child care spent an average of 33% of their income on child care, families between poverty level and \$25,000 spent 13% of their income, and the middle class (families with incomes over \$25,000 at that time) spent 6% of their income on child care (Phillips & Bridgman, 1995).

A study of **Minnesota** low-income working families on the waiting list for child care assistance found that one-fourth of them had to resort to welfare to survive when they could no longer sustain their

child care arrangement (Adams et al, 1998). A past GAO survey found that if AFDC recipients received child care subsidies, work participation rates increased from 29% to 44%, even at a time when there were no time limits or strict work requirements (Waller, 1997). A recent evaluation of the new Florida welfare program found that the factors most often credited for a respondent's decision to enter the work force were support services like child care and transportation. Assistance with supports was named almost twice as frequently as time limits in influencing the decision to get a job (Bloom et al, 1998). To the extent that former welfare families' earnings do not greatly increase over time, their continued ability to maintain employment and support themselves will depend to a great degree on the ongoing availability of child care assistance.

Funding vs Increased Demand for Child Care Assistance

CCDF Insufficient to Cover All Who Are Eligible

The 1996 federal welfare law created a new block grant -- Child Care Development (CCDBG) -- for child care assistance through the Child Care Development Fund (CCDF). The CCDBG provided states with \$2.97 billion in federal funds in FY '97 -- \$605.7 million (or 27%) more than was available in 1996 under previous law for child care assistance programs (Long & Clark, 1997). About a quarter of the funding is contingent on states' continuing investments in child care at the 1994/95 level and spending additional state matching funds. The full combined federal and state funds available for child care programs in FY'97 was \$4.4 billion (GAO, Jan. 1998). HHS reported that all but four states drew down 100% of available federal CCDF matching funds during FY'97 (APWA: 1,3:1998). In FY'98, states obligated all of their mandatory CCDF funds (Falk, 1999). The CCDBG is authorized to increase to \$3.7 billion in the year 2002.

The CCDF can be used for child care subsidies for families who are working or preparing for work, and who have incomes up to 85% of a state's median income (increased from 75% under prior law). The high upper limit allows states to subsidize child care for poor to moderate income working families. At the same time, states are required to use at least 70% of mandatory CCDF and state matching funds for welfare recipients, those transitioning off welfare, and those at-risk of going on welfare. The remaining 30% (and discretionary CCDF) are to be used to assist non-welfare, low-income working families.

Even with these additional funds, states still will not be able to provide child care subsidies to all families meeting federal eligibility criteria who might benefit for such assistance. A GAO sampling of seven states (CA, CT, LA, MD, OR, TX, WI) found that none planned to make child care subsidies available to all families meeting the federal eligibility guidelines (Jan. 1998). It is anticipated that TANF work requirements¹ alone will place a major strain on of child care funding

¹ Several provisions under TANF are intended to increase work activity and therefore the need for child care. Adult TANF recipients must be engaged in a work activity after receiving aid for 24 months and may be required to do

For example, New York City provided subsidized child care for 70,400 children in FY '97, while 20,000 eligible children were on waiting lists. With the enforcement of the "24 months, then work" TANF requirement, an additional 61,000 children annually may need to be served (McCall, 1997). Over two-thirds of the states are uncertain if, in the future, they will be able to meet the additional demands for child care assistance due to the increased work requirements in TANF (Adams et al, 1998).

Child care funds from the various federal and state sources did make it possible for each of the seven states in the GAO sampling to meet their welfare-related child care needs in FY '97, including child care assistance to families transitioning off welfare² (GAO, Jan. 1998). But with the increased demand for welfare-related child care, there is heightened concern that there will be even less funding available for non-welfare, low-income families who traditionally have not been afforded the same level of child care assistance.

Efforts to Stretch Child Care Assistance Funding

In fact, only one in 10 children eligible under federal law are actually receiving child care subsidies (Sherman et al, 1998). Because state child care subsidy programs are so under-funded, many states restrict their own eligibility limits to cover only the poorest families. Families with incomes above \$25,000 are ineligible for assistance in half the states (FCD, 1998). Even so, as of January 1998, about half the states had to turn away low-income working families who meet their stricter eligibility criteria or put them on waiting lists for assistance. For example, in California, more than 200,000 families -- mostly non-welfare, low-income workers -- are on a waiting list for child care assistance (CDF, 1998). Many states do not do extensive outreach to increase awareness of child care subsidies because of fear of overwhelming the system. A recent Children's Defense Fund survey found that only eight states report an ability to serve all families currently eligible under state criteria if those families were to apply for child care benefits (March 1998).

Some states are conserving their child care program resources by imposing higher family co-payments. In recent years, limiting families' out-of-pocket expenses for child care to not more than 10% of their income has become a rather unrealistically high, but accepted, standard (FCD, 1998). Yet, an HHS study found that 22 states exceeded even this high cut-off point and 40 states were

so sooner. States can opt to exempt single parents with a child under one year from this requirement and cannot sanction families for not participating in a work activity if they demonstrate an inability to obtain child care for a child under age six. States must meet escalating overall work participation rates to avoid penalties that reduce their TANF grant.

² Under AFDC, states were required to provide transitional child care assistance for up to 12 months for income eligible families leaving welfare due to increased earnings. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) eliminated this requirement. When developing new programs under TANF and CCDF, half of the states decided to either continue this policy or treat families transitioning off of welfare like other working poor families. The other half of the states decided to extend the period of eligibility for transitional child care assistance anywhere from 18 months up to 36 months, or not to specify a time limit (APWA: 1,1: 1997).

imposing at least some fees on families with incomes below poverty (FCD, 1998). For example, **Colorado** and **Oregon** require parents at the poverty level to contribute 11% of their income for care for one child. In **South Dakota**, the fee for one child with a family income of 150% of poverty would be \$500 per month, or 30% of the family's income of \$1670 per month (Adams et al, 1998). By March 1997, **Wisconsin** had eliminated its late-1996 waiting list of 9,000 families by imposing a new, higher sliding-fee scale, and eliminating entirely subsidies for working families with income over 200% of poverty level (APWA, 1998 & IWPR, 1997).

To provide child care assistance to more families, states have the option to directly use Temporary Assistance for Needy Families (TANF) funds for eligible families³ or to transfer unspent TANF funds into the CCDBG. In a 1997 survey, 12 of 48 states indicated they would transfer TANF funds to the CCDBG (GAO, Jan. 1998). Calculations for FY'98 indicate that states actually used 5.5% of the TANF block grant for child care expenditures (Falk, 1999). To have enough funds to serve all children potentially in need of child care, states would have to transfer the full allowable 30% of TANF funds into the CCDBG⁴, in addition to maximizing all available child care federal matching dollars, each year (Long & Clark, 1997). In FY'97, 30% of TANF was approximately \$4.9 billion.

In fact, about \$3 billion in federal TANF funds for FY'97 and FY'98, combined, were left unexpended and unobligated at the end of FY'98 (Falk, 1999). Even if the full \$3 billion in TANF funds was appropriated for child care expenditures, funding still would be insufficient to provide child care assistance for all children eligible under federal law and in need of care. Regardless, states are not likely to transfer the full amount because they may wish to expend more TANF funds for transportation or education and training, and to hold some of the unexpended TANF funds in reserve for the eventual "rainy day" of a downward turn in the economy resulting in an increased demands for cash assistance.

A small amount of funding for child care assistance also is available through Welfare-to-Work Grants (WtW). The Balanced Budget Act provided \$3 billion over two years for formula and competitive grants to pay for a variety of employment-related activities aimed largely at individuals on welfare facing significant work barriers. To access formula grant funds, a state must provide \$1 in matching funds above its TANF maintenance of effort level for every \$2 it receives. Although initial funding was only for FY'98 and FY'99, the President's FY 2000 budget proposal includes \$1 billion to

³ For a state to receive its full TANF block grant allocation, it must meet a requirement of appropriating 80% of its maintenance-of-effort (MOE) (or 75% if the state meets the work participation rate requirement). The MOE level is based on a state's FY 1994 spending on the welfare programs replaced with TANF and CCDF. A state can use dollars that count towards its MOE for child care expenditures for families in TANF funded programs, and for "eligible families" that meet the state's TANF income and resource standards, but may not meet some other TANF requirements, thus are being served through a separate state funded program. Expenditures for child care assistance from MOE funds are not restricted to employment-related activities, but also can be used for participation in education and training programs (Greenberg, 1998 and HHS, May 1998).

⁴ A total of 30% of the TANF funds can be transferred out of the block grant. Up to 10% can be transferred to the Social Services Block Grant. If a state fully exercises this option, only 20% would remain to transfer to the CCDBG.

extend the WtW grants for a third year.

WtW grants are intended to make additional funding available for certain "allowable activities" for the population of "hard-to-employ individuals" and "individuals with long-term welfare dependence". The regulations for WtW expressly identify child care assistance as one permissible job retention and support service. Child care assistance can be provided after the individual is placed in a job readiness activity, an employment activity, or a job, and only if WtW funds are not substituting for child care assistance funding that would otherwise be available (Greenberg, 1998).

Insufficient Reimbursement Impacts Quality and Availability of Care

Some states stretch child care subsidies by making payments to providers that are far below the market rate. **Delaware**, for example, pays a maximum child care subsidy for a four-year old in a child care center that is \$200 per month less than the amount needed to allow parents to access care from three-quarters of Delaware providers (Adams et al, 1998). This leaves parents with either severely restricted options for placing their children, or in the position of making payments to providers on top of their existing co-payments to cover the actual charge for care. A survey of **Connecticut's** Jobs First welfare program participants revealed that only 17% had their children in licensed day care facilities. Interviewees stated that the child care grant was too low to enable them to afford many licensed providers and that there were not enough slots available among affordable providers to meet the demand (IWPR, 1997). In another study, only 25% of parents who wanted their children to be cared for in formal facilities were using child care centers. Instead they were forced to use informal arrangements which more often led to recurring child care problems (IWPR, 1997).

Under the former AFDC program, reimbursements rates for child care were the lower of the actual cost of care, or a rate sufficient to cover the cost of care charged by 75% of child care providers in the community. Under PRWORA, there is no requirement to pay for child care at the 75th percentile market rate and most states have not conducted recent market surveys to determine the status of their rates. An **Illinois** study found that the maximum state subsidy was well below the rate normally charged by child care providers, with 75 to 100% of providers charging more than the subsidy, rather than the 25% that should have exceeded the maximum subsidy under the AFDC program (WW&F, 1998). In July 1998, HHS attempted to remedy the shortfalls by issuing a regulation requiring states to conduct market surveys at least every two years. Although states are still not required to set reimbursement rates at the 75th percentile, market rate surveys will assist HHS in determining whether the state's rates are sufficient to ensure equal access to the quality of care available to families not receiving subsidies (FCD, 1998).

Low reimbursement rates for child care providers not only discourage acceptance of children relying on subsidies, but also make it difficult to improve the quality of child care services. One study found seven in ten child care centers providing mediocre care, with one in eight providing care that was so inadequate that it threatened the health and safety of children. Another study of family child care homes rated only 9% of the homes to be good quality, while 35% were rated as inadequate (CWLA, 1997). This low quality of care is at least partially due to the fact that programs are able to pay

State Child Care Initiatives

Rhode Island

Rhode Island plans to make reimbursement rates to providers who care for subsidized children more competitive with local market rates by the year 2000 as part of its effort to ensure that child care is universally available to all working families.

Families up to 200% of poverty are eligible for child care subsidies. This will increase to 225% in June, 1999 and further increase to 250% in July, 2000. Rhode Island provides weekly subsidies for child care at the 75th percentile of the range of rates charged, based on a survey of child care costs from 1993. The subsidy increase scheduled for January, 2000 will be based on more recent surveys of market rates, now conducted every two years in Rhode Island. Subsidies are funded largely through state funds, but also with federal money.

In order to ensure child care availability during "off hours" and to improve child care services as a whole, Rhode Island gave \$600,000 in grants for child care improvement and expansion last year. This year, \$1 million will be given in grants. In addition, licensed, uninsured home-based providers who provide care for children from working class families will qualify for state insurance health and dental benefits.

Iowa

In the state of Iowa, child care subsidies are partially financed using TANF funds. In FY'99 Iowa allocated \$44 million for child care, with state resources funding 28% of the program and the remaining 72% from federal funds. Approximately \$5 million (10-12% of the federal funds) in TANF funds were transferred to the CCDBG. The proposed budget for FY 2000 includes an additional transfer of \$3 million from TANF to the CCDBG to further prevent the need for waiting lists for child care assistance.

Iowa families with incomes up to 140% of poverty are eligible for child care subsidies and families with a special needs child are eligible if their income is less than 175% of poverty. The state provides subsidies for children up to age 13 and up to age 18 for children with special needs. Subsidies are provided directly to the child care provider, whether it is a licensed provider, registered home child care facility, or a legal but not registered provider. The amount of the subsidy is determined based on 75th percentile of the market rates survey done in 1996, with a planned increase in 1997.

There are no co-payments for families until they are over 100% of poverty. Iowa's sliding fee payment system is based upon families, not children. In other words, each family pays a flat co-payment, regardless of the number of children in the family unit.

Although there are no special incentive programs for providers to offer infant and toddler care or care during non-traditional hours, currently there are no known waiting lists for either specialized care or regular child care.

trained child care staff very little. Child care center assistants are paid just slightly more than minimum wage; child care teachers, most of whom have college degrees in early childhood education, earn about \$18,988 a year, less than the \$19,656 national average salary of working women with only high school diplomas (Schaefer, 1998).

Responding to Varied Child Care Needs

Although assistance with the cost of child care is essential for families transitioning from welfare to work (and other low-income working families), *affordability* is not the only issue. Age of the child, hours of care needed, special care needs, and care for sick children -- each of these contribute to the challenge that child care support must address. In a recent survey of administrators and providers in 86 cities and counties across the country, just over 50% rated adequate supply of child care for infants in TANF families as a significant problem. About the same percentage rated care for special needs children as a significant problem. The percentage increased to over 60% of the respondents defining off-hours care and care for a sick child as significant problems (APHSA, 1999).

While about 25%, or 2.3 million, of the children in families receiving welfare are *infants and toddlers*, care providers for young children are generally unable to meet even current demands (Kisker & Ross, 1997). When a GAO study assessed the ability of four localities, urban and rural, to meet the demand for infant care, it found that the known supply was sufficient to serve from 11% (Chicago) to 69% (Benton County, Oregon) of demand in poor areas. With the need to respond to the work requirements under TANF, the ability to meet demand will fall to a range of 7 to 54%, respectively (May 1997).

According to the 1990 National Child Care Survey, approximately one-third of working poor parents worked on weekends, nearly 10% worked during evenings, and almost one-half worked a rotating or changing schedule (Kisker & Ross, 1997). These percentages appear to be even higher for families transitioning off of welfare. In Washington state, a random sample of single parents leaving TANF found 35% of those who were employed worked non-day schedules and 51% worked hours that included weekends (NGA, 1998). Of the AFDC recipients leaving the Chicago welfare rolls in 1995 as a result of obtaining employment, 72% reported work schedules that included nights, weekends, or rotating shifts (WW&F, 1998). The GAO study found that the percentage of providers offering *non-standard hours of care* ranged from 12% to 35% in the four localities studied, with these primarily being in family child care homes taking a small number of children (May 1997).

At some time every working parent may face the dilemma of needing to meet job objections and needing to care for a *sick child*. Most child care facilities are not equipped to care for sick children, leaving parents to rely on informal patchwork arrangements. During their first three months in California's JOBS program, more than one-third of the participants experienced problems because child care providers would not care for sick children (Kisker & Ross, 1997). With the supply of providers able to deal with health issues so scarce, care for children with severe chronic health conditions may present an almost unsurmountable barrier to work. A study of AFDC families in Illinois found 15% had children with serious health problems or disabilities (IWPR, 1997).

What Can Be Done: Options and Actions

The Children's Defense Fund has identified goals advocates should set for their state to increase the accessibility and quality of child care for low-income families. To lay the groundwork for state action, CDF recommends that the federal government guarantee at least \$20 billion over the next five years in new funding for the CCDBG, so states may serve all low-income families that need child care assistance. State policies recommendations include:

- Broad child care assistance eligibility guidelines to qualify as many low-income families as possible.
- Copayments that do not exceed 10% of income and do not apply to families under the poverty level.
- Reimbursement rates at 75th percentile of the market to ensure access to quality care.
- Support and incentives for development of care serving the unmet needs of infant and toddler care, sick child care, care for disabled children, and care during non-traditional hours.
- Ensured quality of care by maintaining high health and safety protections for formal facilities and setting at least minimal standards for informal providers and providing training (and possibly low-interest loans or grants to respond to new demands) to both new and seasoned child care providers.

Adapted from The Monitor, Children's Defense Fund, Washington, D.C.: Vol. 1, Issue 2, March 1999.

Although caring for sick children appears to remain unaddressed, states are offering fiscal incentives to establish or expand facilities to respond to other child care needs. In **Oregon**, grants are being provided to child care providers for start-up and ongoing program operations for activities that increase the supply of infant and toddler care, school-aged child care, non-standard hours care, and extended day care linked with Head Start (GAO, Jan. 1998). In **Michigan**, recruitment and training now targets new infant care providers and they are offered start-up equipment, such as high chairs, playpens, and cribs (HHS, 1997). **Illinois** just implemented a policy that offers child care centers an additional 10% in funding per eligible child if 25% of their slots are use by children younger than two years old, at least half of whom receive subsidies (Edgar, 1999). **Illinois** will also fund at least five pilot project offering child care during non-traditional work hours. To better coordinate hours of work with child care, and to ease transportation logistics, **Connecticut** offers tax credits for businesses to establish child care facilities on or near their work sites (GAO, Jan. 1998).

Tax Credits: Another Way of Investing in Child Care

Tax credits for all families with work-related child care expenses are another way to assist families meeting the financial burden. For FY '95, spending on tax-based subsidies through the Child and Dependent Tax Credit (DCTC) and the Dependent Care Assistance Program reached \$3.5 billion,

more than the combined cost of the federal child care programs that were later consolidated into the Child Care Development Block Grant. Through the DCTC, families receive a nonrefundable credit against taxes for a percentage of child care expenses related to employment. Families with an adjusted gross income under \$10,000 can claim a credit equal to 30% of their child care expenses. Allowable expenses are limited to \$2,400 for one child and \$4,800 for two or more children. The credit phases down from 30% to 20% of eligible expenses for taxpayers with incomes between \$10,000 and \$28,000. For families with income above \$28,000, the 20% rate remains fixed.

Twenty-four states have dependent care tax credits or deductions, 14 of which tie their credit to the federal DCTC. Seven states have refundable credits -- **Arkansas, Colorado, Hawaii, Iowa, Minnesota, New Mexico, and New York.** Minnesota has the most generous program, providing a refundable credit targeted to low-income families. Parents with incomes under \$16,050 can generally claim 100% of the amount they are eligible to claim for the federal DCTC, even if they owe no taxes. Families with incomes over \$29,700 are not eligible for the state credit. In between these income levels, the credit amount decreases as income increases (Schaefer, 1998).

The major criticism of the federal DCTC, and many of the state tax credits, is that they are not refundable and therefore do not benefit very low-income families who generally owe little or no taxes. A recent analysis by the National Women's Law Center showed that there are virtually no families eligible for the highest credits against taxes -- 26-30% of their child care expenses -- since even families with only one or two children do not pay taxes at the income levels eligible for these percentages (Schaefer, 1998). The current limits on allowable child care expenses were established in 1981 and have not been adjusted for inflation. As was noted earlier in this report, the average cost of child care is two to four times the limit of allowable expenses depending on the region of the country.

In the FY 2000 budget, the President proposes to increase the federal maximum child care tax credit rate from 30% to 50% of expenses, and to allow families with income of \$30,000 or less to claim the maximum credit. The credit would be phased down to 20% at the \$60,000 income level and remain fixed after that. The President's proposal will increase the tax credit provided to many families but still does not assist the poorest families. While providing a tax credit to the highest income families, the very poor families who owe no taxes receive nothing, because there is no refundable credit provision. These families will continue to face child care expenses that are a substantial portion of their earned income without DCTC offsetting some of the costs.

See the "References and Resources" section of this report for identification of references cited in this section.

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